A REVIEW OF HEALTH CARE DELIVERY FOR ABORIGINAL PEOPLE IN CANADA WITH RECOMMENDATIONS FOR IMPROVING HEALTH OUTCOMES

by

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ABSTRACT

The purpose of this research project is to examine and discuss the inadequate delivery of health care to Aboriginal people in Canada. This paper will utilize Aboriginal health research literature and health data to examine Aboriginal health status, and the mechanism of health care delivery for Aboriginal people. Factors such as differing perspectives about health, the power imbalance within the health system, language and culture barriers, and relationship development will be discussed. Recommendations to improve health outcomes will be presented.

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Glossary

First Nations and Inuit Health Branch (FNIHB)

Indian and Northern Affairs Canada (INAC)

National Aboriginal Health Organization (NAHO)

Royal Commission on Aboriginal Peoples (RCAP)

Public Health Agency of Canada (PHAC)

Aboriginal Peoples Survey (APS)

Canadian Community Health Survey (CCHS)

Non Insured Health Benefits (NIHB)

Canada Mortgage and Housing Corporation (CMHC)

Canada Health Transfer Act (CHT)

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I. Introduction

The report of the Royal Commission on Aboriginal Peoples (1996) provides evidence that indicates that Aboriginal people benefited from good health at the time of first contact with Europeans. Historical records and the findings of modern paleo-biology suggest that many of the illnesses common today were once rare, and that mental and physical vitality prevailed among Aboriginal people. Furthermore, Aboriginal people were recognized as nature physicians, apothecaries and doctors because of their knowledge and experience of certain herbs, consistent with more than 500 drugs used in the medical pharmacopoeia today. It was estimated that at the time of contact in the region that became Canada, the Aboriginal population was 500,000. Since early contact, Aboriginal people have signed treaties with the British Crown to ensure their survival. Over the past four hundred years, infectious diseases, wars and federal legislation leading to the loss of traditional lands, the reservation system and residential schools have all had a negative impact on the mental and physical vitality that once existed among Canada's Aboriginal people. Further repercussions include the loss of identity, community cooperation and poor socio-economic status.

Federal legislation and the reservation system also had an impact on the lives of Aboriginal people, which created a situation where they were no longer free to gather traditional foods and hunt, but became dependent on government rations, processed food from stores and government funding. Current research provides evidence that this rapid diet change (from traditional foods to processed foods) and a sedentary lifestyle is a leading factor of the current diabetes epidemic for some Aboriginal people. Contemporary health issues experienced by

Aboriginal people are frequently due to a history of oppression that is often not understood by the health system. The health status of Aboriginal people is defined and understood through an analysis of health data and the historical, social, economic, and political impacts of colonialism by the nation state on the lives of Aboriginal people. The issue to be identified and examined in this research project is that the delivery of health to Aboriginal people in Canada is not adequate. Inadequate health care delivery stems from the impact of unequal historical relationships between Aboriginal people and the nation state, and different philosophies on health. These factors lead to poor, unbalanced relationships between Aboriginal people and the health care system, creating even greater gaps and disparities in health status. Without timely, convenient access to health care, the result is poor health status, and increased cost pressures on the system.

The purpose of this paper is to review research literature pertaining to Aboriginal health data, identify barriers and issues for Aboriginal clients accessing health care delivery in Canada, examine Aboriginal traditional approaches to healthcare, and make recommendations utilizing the concept of cultural safety to improve health outcomes of Aboriginal people. Cultural safety recognizes the social, economic and political position of Aboriginal people as an important factor to understanding current health status and issues. In order to understand the current health care issues experienced by Aboriginal people, the historical context of Aboriginal health will be described when appropriate.

In certain sections of this report there may be a British Columbia and Ontario bias, as the writer worked within the field of Aboriginal health in these two provincial levels of the health system. This report begins with a discussion of Aboriginal health data and issues, health care delivery in Canada, traditional aboriginal approaches to health care delivery, current needs of

Aboriginal clients, cultural safety and testable propositions. The subsequent sections of this report include a discussion of propositions, recommendations for system change (including a proposed model) and conclusions. This report uses population data and health statistics of the Aboriginal people of Canada gathered from publications developed by FNIHB, provincial health authorities, Statistics Canada and Aboriginal health sources. Research literature is gathered from various periodicals and scientific journals.

The term *Aboriginal people* is used to refer to the indigenous people of Canada as a general reference to Inuit, First Nations and Métis people. The term *Aboriginal people* refers to structured political and cultural entities originating historically from the original peoples of North America. The term *Aboriginal people* includes the Indian, Inuit and Métis peoples of Canada as defined by section 35(2) of the Constitution Act, 1982. The Aboriginal population of Canada is the primary focus of this report; however, the term *First Nations* will be used in relation to health data specific to the First Nation population. The term *First Nations people* refers to status Indians defined by the Indian Act.

2. Literature Review

(i) Aboriginal Health Issues and Statistics

Aboriginal health information is gathered by the health system through federal and provincial/territorial data collection processes. Aboriginal health statistics are extrapolated from the data collection process to determine health status. Each provincial and territorial government has different infrastructures, and health data collection processes vary. Personal health information and data for Aboriginal people is gathered in various ways, often depending on the health care provider when a client interacts with the health system. This data collection process is dependent on the way the provincial government defines Aboriginal people, and whether it uses Aboriginal identifiers and data-sharing agreements between federal and provincial/territorial health departments.

Data collection differs for Aboriginal people defined as status First Nations. INAC is responsible for the Indian Register, which lists all persons registered under the Indian Act legislation as being a status Indian. The FNIHB publications pertain only to status First Nations and/or Inuit people. An example of data collection occurs when a First Nations client provides their status card to a dental office for services, and the cost is paid by the federal government. These services are non-insured health benefits (NIHB). In some cases, specific requirements disable First Nations clients from accessing the NIHB services. The process for Métis and non-status Aboriginal people differ, as they do not have a status card; therefore, they utilize their provincial health card.

Research studies and government publications use the term *Aboriginal people*; however, the definition of *Aboriginal population* differs in the various studies. For instance, the definition

of *First Nations people* in the Aboriginal Peoples Survey (APS) differs from the definition used by Statistics Canada and the Canadian Community Health Survey (CCHS). The three categories of Aboriginal people are not consistently defined and create challenges for examining specific Aboriginal populations. The changing definition used by Census Canada further compounds this challenge (Browne, A.J., McDonald, H., & Elliot, D., 2000, p.2) and illustrates the history of categorisation of Aboriginal peoples by the Canadian state. In effect, the state creates a barrier to accessing the reliable data required for evidence-based decision-making.

According to the Indian Register (Health Canada, 2009, p.4) status Indians living both on and off reserve numbered 717,276 in 2002. In contrast, the 2006 Census (which collected data for status and non-status First Nations people, Métis and Inuit) revealed that the total Aboriginal population in Canada was 1,172,790. Table 1 illustrates the 2006 Census population in the three categories of Aboriginal identity broken down by province. According to the three categories, the breakdown of the total Aboriginal identity population of Canada consists of a North American Indian population of 59.5%, a Métis population of 29.1%, and an Inuit population of 4.3%.

Figure 1: 2006 Census - Aboriginal identity population for Canada, provinces and territories.

Geographic name	Total population	Aboriginal identity population[1]	North American Indian	Métis	Inuit	Non-aboriginal identity population
Canada	**31,241,030**	**1,172,785**	**698,025**	**389,780**	**50,480**	**30,068,240**
Newfoundland and Labrador	500,610	23,455	7,765	6,470	4,715	477,160
Prince Edward Island	134,205	1,730	1,225	385	30	132,475
Nova Scotia	903,090	24,175	15,240	7,680	325	878,920
New Brunswick	719,650	17,650	12,385	4,270	185	701,995
Quebec	7,435,905	108,425	65,085	27,980	10,950	7,327,475

Ontario ‡	12,028,895	242,495	158,395	73,605	2,035	11,786,405
Manitoba ‡	1,133,515	175,395	100,640	71,805	565	958,115
Saskatchewan ‡	953,850	141,890	91,400	48,120	215	811,960
Alberta ‡	3,256,355	188,365	97,275	85,495	1,610	3,067,990
British Columbia ‡	4,074,385	196,075	129,580	59,445	795	3,878,310
Yukon Territory ‡	30,190	7,580	6,280	800	255	22,615
Northwest Territories	41,060	20,635	12,640	3,580	4,160	20,420
Nunavut ‡	29,325	24,915	100	130	24,635	4,405

Trends of the 2006 Census reveal a large increase in the Aboriginal population (45% in the past 10 years). This rate of growth is nearly six times that of the non-Aboriginal population (8%). Aboriginal people in Canada are increasingly urban (as illustrated in Table 1), with a list of the seven highest Aboriginal populations in an urban location in Canada. In 2006, 54% of the Aboriginal population in Canada lived in urban areas, up from 50% in 1996. Often Aboriginal people move to urban areas to pursue post-secondary education, health care or employment. Another motivation is the lack of housing on reserve. Almost half (48%) of the Aboriginal population is composed of children and youth aged 24 and under, compared with the 31% of the non-Aboriginal population. This young Aboriginal population will have a significant impact on social services, housing, education, labour force and health services for policy and government officials.

Table 1 - Top 7 largest urban Aboriginal populations (2006 Census data).

	City	Aboriginal population
1	Winnipeg	68,380
2	Edmonton	52,100
3	Vancouver	40,310
4	Toronto	26,575
5	Calgary	26,575
6	Saskatoon	21,535
7	Regina	17,105

FNIHB has developed a national description of the non-medical determinants of health among First Nations people on-reserve in Canada. The non-medical determinants of health include education, labour force characteristics, personal health practices, culture and physical environment. (Health Canada, 2009, p.1) A health determinants approach is similar to the Aboriginal perspectives of health, as it takes into consideration the physical, social, emotional and spiritual domains. The health determinants approach considers life stages, interactions between social and economic factors, the physical environment and individual behaviour. Health determinants in combination form an Aboriginal person's health status.

Table 2 - Health determinants highlights - First Nations people. (Health Canada, 2009, p. iv-v)

	First Nations people on reserve	Canadians
University certificate diploma, or degree	5.1%	22.7%
less than high school diploma	48.6%	22.5%
graduated high school by age 20	36.0%	84.6%
unemployment rate	27.7%	7.3%
employment rate	37.4%	61.7%
median annual income	$10,631	$22,274
smoking	58.8%	24.2%
heavy drinking on a weekly basis	16.0%	7.9%
Mammogram -ages 50-59	77.3%	88.3%
Aboriginal language mother tongue	44%	
households below CMHC adequacy standard	22.4%	2.0%

Overall, the health determinants data illustrate that First Nations people have lower education attainment levels and are less likely to graduate from high school than other Canadians, even at an older age. Education attainment is necessary to participate in many skilled and knowledge-based sectors of the labour force, thus resulting in increased employment and higher income. Employment status effects overall health, while a higher income job can have positive effects on a person's overall quality of life. Collectively, such advantages have a direct impact on the overall health of the population. This data indicates significant inequities in employment/unemployment and labour force characteristics between on-reserve First Nations people and the general Canadian population, thus creating significant inequity for the health status of First Nations people on reserve. Individual behaviour such as smoking, alcohol consumption and health screening are important factors to consider when assessing health status. Smoking and heavy alcohol consumption on a weekly basis is over double the rate of the general Canadian population. A significant issue confronting health care delivery, for example, is that Aboriginal people are disproportionately represented in the statistics related to substance abuse and HIV infection (Northern Health, 2006, p.20). A risk of reproducing negative stereotypes about Aboriginal people occurs when examining health data without contextual information. Culturally appropriate health prevention, promotion and education strategies are a requirement for the system to respond to the needs of Aboriginal people.

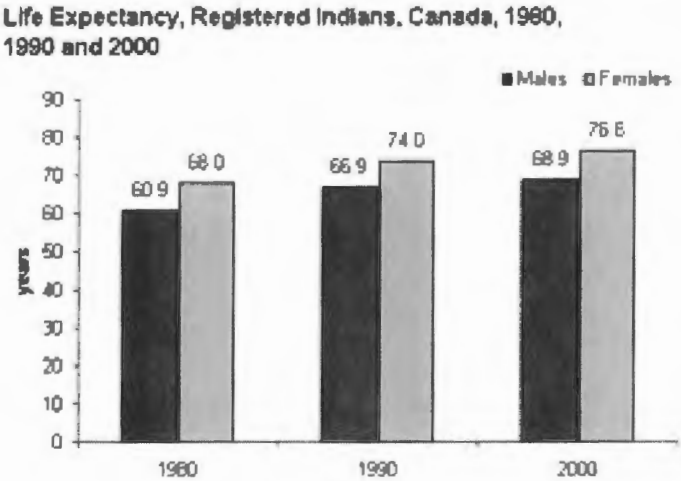
The impact of historical policies with the purpose of breaking down Aboriginal culture and language is reflected in the fact that over half of Registered Indians on-reserve learn English

as their sole mother tongue, whereas 44% of Registered Indians on-reserve have learned an Aboriginal language as their mother tongue (either alone or in combination with English or French) (Health Canada, p.31, 2009). The language barrier is an issue the health system needs to respond to in order to obtain informed consent from clients. In some areas of British Columbia the health system employs Aboriginal Patient Navigators to provide support to Aboriginal clients to assist and guide them through our complex health system. The health determinants data illustrate that the proportion of Aboriginal on-reserve households that are below the CMHC adequacy standard is over ten times that of households in the general off-reserve population (Health Canada, 2009, page v). Nearly a quarter of First Nations housing units have a water supply that is inadequate in terms of volume and/or health requirements.

Provincial vital statistics provide basic information on health indicators such as mortality, life expectancy and birth related statistics, but they almost exclusively pertain to status First Nations people. In some provinces or territories, statistics are often reported by health service delivery areas and can be compared to the overall population. Only data collection in British Columbia and Alberta include on- and off-reserve status populations. Provincial vital statistics make it difficult to examine health data for urban First Nations people using population-based datasets (Browne, A.J., McDonald, H., & Elliot, D., 2009, p.2). Furthermore, data cannot be disaggregated into categories reflective of First Nations people living in urban versus rural areas, since Aboriginal people may move back and forth between urban and rural areas. Life expectancy is an international health status indicator, and as illustrated in Figure 1, the life expectancy of registered Indians has increased in a 20-year span; however, there is still a

significant difference from the general population's life expectancy, suggesting challenges and antecedent issues.

Figure 2: Life Expectancy, Registered Indians, Canada, 1980, 1990, 2000. (Source: INAC, 2001, Basic Departmental Data, 2001, Catalogue no. R12-7/2000E)



Preventable admissions are conditions usually managed in the community without the need for hospitalization if clients have convenient and adequate access to services (Northern Health, 2007, p. 22). Preventable admissions are useful for measuring the effectiveness of services to Aboriginal people. In northern British Columbia, the preventable admission rates amongst status First Nations people have over double the rate of hospitalization than the rest of the population (Northern Health, 2007, p.22). This suggests the possibility that Aboriginal clients do not have convenient access to primary health care, and/or they may not have a regular physician therefore they present to the emergency department with a progressed illness that may have been treated in its earlier stage.

In general, Aboriginal people are more likely to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, and inappropriate or absent services. Consequently, they experience high rates of physical, social and

emotional illness, injury, disability and premature death (RCAP, 1996, p. 107). Similarly, the Aboriginal population ranks lower on all educational attainment indicators, experience higher rates of unemployment, along with higher rates of smoking, alcohol and substance abuse (Shah, C.P., 2005, p. 3). Furthermore, the Aboriginal population experiences a disproportion burden of many infectious diseases, and the prevalence of self-reported chronic conditions, injury rates and mental disorders is higher than in the general population. In conclusion, Aboriginal populations have significantly poorer health status than other Canadians.

In summary, the health indicators and health determinants presented in the preceding section display significant health disparities for Aboriginal people. The most reliable health data and statistics is collected provincially/territorially when a First Nation client uses their status card, but the data is only specific to status First Nations people and does not include Métis and non-status Aboriginal people.

ii) Health Care Delivery

The Government of Canada administers the Canada Health Act, with its main objective as defined by Canadian health care policy, which is to protect, promote and restore the physical and mental well-being of residents of Canada, and to ensure reasonable access to health services without financial or other barriers (Health Canada, 2008, p.8). The Act specifies the five principles of Medicare (universality, accessibility, portability, comprehensiveness and public administration), which the provinces and territories must follow in order to receive their share of the federal cash contribution under the Canada Health Transfer. Canada's federal, provincial and territorial governments ensure that Canadians have access to insured health services on the basis

of need, and not their ability to pay. In 2008, total health expenditures in Canada were forecast to reach $171.9 billion, and in 2007–2008, resources of approximately $2.1 billion were made available for First Nations and Inuit health programs (Health Canada, 2008, p.14).

Aboriginal people obtain health care services primarily through provincial health systems. FNIHB is responsible for providing health services to First Nations and Inuit populations. FNIHB supports the delivery of public health and health promotion services on-reserve and in Inuit communities, and it provides some services off-reserve and in urban centres. FNIHB provides primary health care services on reserve in remote and isolated areas, where there are no provincial services available (Health Canada, 2009, p.2). Other services provided on reserve include disease prevention and health promotion programs, public health, environmental health, alcohol/drug addiction treatment, and home and community care services. Aboriginal health workers report the issues of little flexibility and insufficient funding with FNIHB funded programs to operate a viable program or to include aboriginal traditional healing perspectives.

First Nations people are entitled to universal health care administered through the provincial health care systems, and they receive health coverage from the federal government for certain medically necessary services not normally covered by the universal health care system. This includes prescription drug coverage, dental and vision care, as well as coverage for emergency transport. NIHB includes drug, dental care, vision care, medical supplies and equipment, mental health services and medical transportation. NIHB is available to approximately 799,000 registered Indians and recognizes Inuit in Canada, regardless of residence. NIHB is not available for non-status First Nations people or Métis people.

Health services delivered by provincial governments consist mainly of hospitals, primary health care, long-term care, and mental health and addictions. For each province and territory in Canada, the manner in which the provincial health system engages and involves Aboriginal people varies. Some provincial governments seek to engage in relationships with Aboriginal people to identify their health care requirements. Aboriginal people invited to participate in discussions with provincial health authorities report feelings of tokenism and frustration due to the prevalence of equal relationships, and the process often lacks the mandate to make policy and service changes. A cultural safety approach to forming this relationship would acknowledge the historical context of Aboriginal health, as many non-Aboriginal policy makers and government officials lack the understanding of the social, political, and historical factors leading to the current health requirements of Aboriginal people.

Lavoie, J., (2005), describes the Constitutional Act of 1867 identified health care as a provincial jurisdiction and status First Nations people as a federal jurisdiction. This Act created a jurisdictional debate over First Nations health care delivery that continues today. Aboriginal clients often report issues regarding jurisdictional barriers to health care. In many cases they are denied service, as health care is defined as a provincial service while a status First Nations client is federal jurisdiction.

Many First Nations communities do not have primary health care delivery on reserve, as this is a provincial service. This creates a significant barrier to residents who live on a reserve. The primary health care physician enables Aboriginal clients to receive the specialized services they require by providing them a referral for services. Unfortunately, Aboriginal clients without a primary health care physician are unable to receive the necessary support services to assist in

the self-management of their illness or condition, often resulting in a more rapid progression of their illness, thus increasing cost pressures on the system.

The manner in which Aboriginal clients perceive and respond to health delivery services today is the result of over a century of decision-making and policy development by the nation state. Findings from a research study suggest that Aboriginal clients report invalidation encounters (Browne, A.J., Fiske, J., & Thomas, G., p.13-20, 2000). These invalidation encounters include being dismissed, negative stereotypes, transforming one's self, marginalization from mainstream, situations of vulnerability, and disregard for personal circumstances. The risk of being dismissed by a client is further compounded by the reluctance to admit pain or suffering, which research participants explain they were taught in residential school. This situation may increase preventable admissions and barriers to accessing health care. Overall, the invalidation encounters illustrate discrimination directed at Aboriginal clients.

Conversely, affirming encounters with the health system include a client's active participation in health care decisions; feeling genuinely cared for; affirmation of personal and cultural identity; and development of a positive long-term relationship with a health care provider (Browne, A.J., Fiske, J., & Thomas, G., 2000, p. 20-26). These four affirming encounters provide insight and definition on what health care providers can do to improve health care interaction with Aboriginal clients. The findings of this study highlight the importance of viewing Aboriginal women in terms of the larger social, economic and political forces influencing their lives and their encounters with the Canadian health system.

The federal and provincial/territorial governments should implement education strategies for health service providers that work with Aboriginal clients to understand how Aboriginal

languages and culture was diminished by the federal government's residential school policy. The system is providing health services to residential school survivors and/or parents, or grandparents who were legally required to turn over their children to the custody of residential school. Health service providers need to understand the historical context of their clients in order to provide quality, culturally safe care that is respectful of the client's needs.

The historical relationship between Aboriginal people and the state was characterized by the state holding the power for policy development and decision-making with regard to Aboriginal people. The results of this policy development affect the current, social, political and economic reality experienced by Aboriginal people. Current strategies by federal, provincial/ territorial governments to engage with Aboriginal communities in health care planning face the challenge of a colonial relationship often characterized by mistrust, misunderstanding and paternalism.

iii) Traditional Approaches to health care delivery

> Traditional healing methods were decried as witchcraft and idolatry by Christian missionaries and ridiculed by most others. Ceremonial activity was banned in an effort to turn hunters and trappers into agricultural labourers with a commitment to wage work. Eventually, the Indian Act prohibited those ceremonies that had survived most defiantly, the potlatch and the sun dance. Many elders and healers were prosecuted. In these ways Aboriginal people were stripped of self-respect and respect for one another (RCAP, 1996, p.113).

The traditional Aboriginal approach to health is most commonly described as holistic, encompassing health determinants, fostered by indigenous knowledge, and community based and driven. The traditional Aboriginal approach includes physical, mental, emotional and spiritual aspects of self, family, community and nation. It also includes concepts of wholeness, balance,

and the importance of relationships with family, the community and the natural environment. The Aboriginal world-view is rooted in deeply held values including family and community, and it includes the way the world is experienced and explained.

The Aboriginal world-view is based upon the life experience and history of Aboriginal people. As an example, mental wellness and illness is understood differently through the indigenous point of view than that of mainstream Canadian society, and it requires recognition of the intergenerational effects of colonization. In the case of students who attended residential schools, the intergenerational effects include the direct impact of loss of culture, identity, language, knowledge and experience of Aboriginal family systems practices. An Aboriginal perspective of health refers to personal and societal recovery from the effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not only from specific illness and social issues but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect (RCAP, 1996, p. 109).

Traditional Aboriginal approaches to health care delivery include an understanding of the reality they encountered, in addition to that of their parents, grandparents, and all other members of the community. Today, Aboriginal clients who access the health care system may have attended residential schools, and the institutional setting of the hospital may activate the client's experience of the institutional setting of the residential school. The client may exhibit feelings of abuse and mistrust, and these are important factors for non-Aboriginal health care providers to understand in order to provide support, understanding and safety for the client.

Aboriginal seniors are important for the transmission of culture as role models, and as practitioners of traditional healing methods, including the harvesting of traditional medicines. The Aboriginal health care system that existed prior to contact was developed by Aboriginal people, and it includes traditional healers, midwives, aboriginal knowledge, and use of an aboriginal holistic model of care. This model addresses the physical, mental, emotional and spiritual aspects of individual, community and nation. In the 1990s urban Aboriginal health centers were established in some provinces to offer primary health care to urban Aboriginal clients who were often denied services. Access to timely health care is challenged by the inability of the health care providers to understand and acknowledge the intergenerational impact of colonization.

The Aboriginal traditional perspective of health is similar to the health determinants approach. The determinants of health categories as summarised by the Public Health Agency of Canada, (Health Canada, p.1, 2009) consist of the following twelve categories:

1. Education
2. Labour force characteristics
3. Income
4. Personal health practices
5. Health services
6. Culture
7. Physical environment
8. Social support networks
9. Social environments
10. Child development
11. Biology and genetic endowment
12. Gender

The determinants of health can be considered as aspects of a whole, which is symbolised by the Medicine Wheel, featuring the physical, mental, emotional and spiritual dimensions of self. The

Medicine Wheel is a paradigm used by some Aboriginal health practitioners as a tool to express the healing process. Each determinant is necessary to meet a person's needs related to the four aspects of self in order to achieve holistic health.

(iv) Current system versus the needs of Aboriginal people

There are several ways in which the current health system fails the needs of Aboriginal people. The health system fails the health care needs of Aboriginal people by their inability to understand the historical context of Aboriginal health, different perspectives of health, the power imbalance, data collection issues and systemic discrimination.

The current health system fails Aboriginal people because their current illness service model does not reflect the holistic approaches of aboriginal traditions, nor does it acknowledge the socio-political and historical context of aboriginal health. As an example, Smye and Browne, argue Aboriginal people accessing mental health services provided by the mainstream Canadian health system tend to drop out of services, and for many of them the treatments are not effectual. Mainstream mental health service practitioners do not understand their cultural ways, or the historical context of Aboriginal health.

Browne (2000) argues Aboriginal clients describe their experience with the system as discriminatory in terms of marginalization from mainstream health services. Furthermore, they state their sense of being on the outside and intruding on the system and as lacking connection to the social process inherent in mainstream health systems. The health service provider may miss the underlying social factors contributing to the client's behaviour in a physical exam, which

further impacts health delivery. This illustrates how health care providers who lack the understanding of their client's social circumstances provide inadequate care.

In summary, the health system fails the needs of Aboriginal people by dismissing and devaluing the voice of the client, and because the current system is the bearer of power, the client is often powerless. Data collection is limited by definitions, inconsistent collection methods, and lack of Aboriginal identifiers for Métis and urban aboriginal people.

(v) Cultural Safety

According to Smye and Browne (2002, p. 46) the concept of cultural safety was first developed by I. Ramsden, a Maori nurse leader from New Zealand based on her experience with the colonising processes that occurred in New Zealand. The colonising processes disregarded the illness and health belief systems of the Maori people of New Zealand, and favoured the dominant non-Aboriginal culture in the construction of the healthcare system. The concept of cultural safety refers to recognition of the social, economic and political position of Aboriginal people, and enables a lens to view inequities in healthcare delivery. A cultural safety approach focuses on power imbalances and on individual and institutional discrimination and how these play out in health care practices. Furthermore, Smye & Browne refer to the development of cultural safety as a view to resist the tendency in health care to create culture risk situations that arise when people from a particular group believe they are devalued, diminished, or disempowered by the actions and the delivery systems of people from another culture. The principles of cultural safety can be gained by understanding that safe practitioners recognize, respect and acknowledge the rights of people.

Further exploration is needed to develop ways of integrating the concept of cultural safety into policies guiding health services to Aboriginal patients. Policies that address cultural safety can provide a mechanism for linking macro-level issues to micro-level interactions in a health care context. Cultural safety is applicable to service delivery, research and policy across diverse populations (Smye V., and Browne, A.J., 2002, p.53) but it is very useful in the area of Aboriginal health because of the historical context of Aboriginal health.

Cultural safety applied to the Canadian experience considers the colonial relations of Aboriginal people with the federal and provincial governments as they continue to shape access to health care, health care experiences and health outcomes. Cultural safety is a process, and it would require recognition by the system that health care delivery for Aboriginal people is inadequate. As an example of this recognition, in 2005, the BC government developed a trilateral agreement with First Nations leadership and the federal health department in an effort to develop a plan to strengthen their relationships on a government-to-government basis. (First Nations leadership refers to elected Chief and Council members as defined by the election process of the Indian Act). They affirmed their commitment to achieving three goals:

1. Close the gaps between First Nations and other British Columbians in the areas of education, housing, health and economic opportunities over the next 10 years;
2. Reconcile Aboriginal rights and title with those of the Crown, and;
3. Establish a new relationship based on mutual respect and recognition. (British Columbia, Tripartite First Nations Health Plan, 2007)

Browne (2006) research study examining interactions of Aboriginal clients and the health system based their study on the concepts of cultural safety and structural communication; it sought an understanding of the structural barriers that women encounter and of the social and health implications of these barriers. The study was concerned with the way structural

communication reinforced inequality between Aboriginal people and non-Aboriginal authorities, giving the state influence over local ideas and actions that affect women's cultural safety. Cultural safety in health research enables increased understanding of the power imbalance and ways to alter and allow transfers of power to First Nations governments. Through this research, the concepts of cultural safety and structured communication help us to understand how political economic structures constrain isolated efforts to reform policy and practice.

(vi) Testable propositions

This section of testable propositions include a series of six statements derived from the literature review that link cultural safety to health care and improved health outcomes for Aboriginal people. Based on the findings from the literature review, the following list was developed.

1. Recognition by the Canadian health care system that health care delivery for Aboriginal people is inadequate due to a power imbalance.
2. Long-term positive relationships with health care practitioners who acknowledge the historical context of Aboriginal health will support client needs, enabling them to access services and create increased access to the system.
3. Empowering and valuing the voice of Aboriginal people as they interact with the system will increase access and improve health outcomes.
4. Integration of traditional Aboriginal approaches to health care with mainstream approaches will encourage aboriginal people to access the system.
5. Creating health prevention strategies that fit the aboriginal perspectives and address the root causes of despair will encourage Aboriginal people to access the health care system more frequently and improve health outcomes.
6. Coordination of data collection by the system will enable consistency of Aboriginal definitions in data collection process for reliable evidence for all Aboriginal populations.

3. Discussion

This discussion will focus on the six testable propositions derived from the literature review. The first statement suggests that the system needs to recognise that health care delivery for Aboriginal people is inadequate due to a power imbalance favouring the dominant society. As an example, the British Columbia government developed a trilateral process to close the gap on health inequities experienced by Aboriginal people in the province. They recognise health status is inadequate, and developed policy tables with the First Nations leadership council. The two levels of government have sought a new relationship with the First Nations leadership council (First Nations Leadership Council consists of organizations representing First Nation communities in the province of British Columbia) and would like a government-to-government relationship recognising the First Nation government process. The process is flawed because it does not discuss the historical context of Aboriginal health; it requires equal power from all partners and the ability of First Nations to make meaningful change to the areas that require change. The process requires a cultural safety approach to view the structural inequities and power imbalances and their role in influencing health.

The second statement proposes long-term positive relationships with health care practitioners who acknowledge the historical context of Aboriginal people in order to support and understand clients, further enabling and facilitating Aboriginal access to services when they are needed. This objective could be incorporated into the system by developing a documented historical context of Aboriginal health based on the history of the local communities. It would require cultural resource people locally that hold the cultural and historical knowledge. Education and training with health care practitioners is required to ensure knowledge

transmission. In addition, health authorities would need to approve and acknowledge the purpose and importance of increasing education and awareness of system staff. Health authorities need to develop a process to ensure that health care practitioners are available to accept new clients. The system needs to provide primary health care at the Aboriginal community level, as transportation is a common barrier for clients to access service.

The third testable proposition refers to empowering and valuing the voice of Aboriginal people with the goal of increasing health care access and improving health care outcomes. The key to successful implementation of cultural safety is the client's ability to define safe services through community development processes where the Aboriginal communities define cultural safety. An approach to incorporate this into the health care system involves developing meaningful relationships with all provinces, territories and the federal government to work with Aboriginal governments in a consultative process. The process would define cultural safety jointly and developing a plan to implement appropriate processes.

The fourth testable proposition proposes the integration of traditional Aboriginal approaches to health care in cooperation with mainstream approaches to encourage aboriginal people to access the system. The health determinants approach can be expanded upon with the use of the Medicine Wheel to illustrate the factors that give rise to health status. Provincial, territorial, federal and Aboriginal governments need to develop a process to ensure Aboriginal traditional approaches are reflected in current health strategies. Urban Aboriginal health centres are a point of contact for clients to use traditional Aboriginal healers, midwives and complementary holistic health practices. Planning would be required to determine the needs of Aboriginal clients, Aboriginal healers and the necessary mechanisms to ensure cultural safety.

The fifth statement suggests that creating health prevention strategies to fit with Aboriginal perspectives and address the root causes of despair would also facilitate and increase Aboriginal access to health care and improve health outcomes. Health reforms occur throughout the system, and it is imperative that health authorities involve and consult with Aboriginal people. Aboriginal people need to be consulted to identify their specific requirements as it relates to health programs and services. For example, if health reform occurs, such as a mental health strategy, it needs to involve Aboriginal mental health specialists to advise and recommend on the consultation process. The consultation process would involve visits to all Aboriginal communities in the region to ensure that the requirements of Aboriginal clients are reflected in the mental health strategy. Thus, the resulting mental health strategy reflects the needs of Aboriginal clients, and they would access the services that are more culturally responsive. The historical context of Aboriginal health issues needs to be written, and health authorities need to ensure that the necessary education process is created for all health care providers working with Aboriginal clients.

The sixth statement refers to the coordination of data collection by the system, thereby enabling consistency of Aboriginal definitions in data collection process to ensure reliable data for use by all Aboriginal populations. In particular, urban Aboriginal and Métis people require specific data for their populations to make informed decisions in health care delivery and policy. In order to incorporate this process into the system, the data collection departments of the various levels of government need to meet to discuss and implement a plan for consistent definition of Aboriginal people in Canada.

4. Recommendations

a. Model of proposed system

The primary goal of the proposed system is to improve the health outcomes of Aboriginal people within a specific timeframes. The proposed system would use the five principles of health care with a focus to eradicate the jurisdictional debate and to ensure accessible health care. The model of a proposed system would use the principles of cultural safety at the onset to ensure planning, implementation and evaluation is enabled by a lens to view the existing power imbalances, and take into consideration the socio-political and historical realities of Aboriginal people. The proposed system requires training in cultural safety by experts in the field. For example, the School of Nursing at the University of British Columbia, hold expertise in cultural safety and should be consulted to develop the best approach for a system wide change to educate nurses and physicians to impact the health care delivery experience of Aboriginal people. Health professional associations such as the provincial medical associations, nursing associations, and education institutions need to identify mechanisms to develop competencies in cultural safety. The School of Nursing, University of British Columbia would be consulted about their cultural safety curriculum.

The proposed system would be community based and involve Aboriginal governments at the beginning to ensure their meaningful involvement. The proposed change involves all levels of government including Aboriginal governments. A medicine wheel tool constructed to define the process and include the determinants of health and indigenous health.

The proposed system change will acknowledge current agreements, such as the First Nations Health Accord in British Columbia and the Aboriginal Healing and Wellness Strategy in

Ontario. The concept of cultural safety needs to be defined at the community level to be integrated regionally with existing processes. System change occurs to enhance and build upon the existing health infrastructures with the inclusion of a cultural safety component to enable the system to view health care delivery through a different lens. The primary goal of the proposed system is to enable reliable health data to inform health policy and system delivery requirements to ensure improvements in health status for Aboriginal people.

b. Recommendations for change

The following list is the recommendations for change from this research study. These recommendations must be conducted with all levels of government including Aboriginal governments.

1. Redesign health care delivery for Aboriginal people. Redesigned services to fit with aboriginal perspectives of health and cultural safety.
2. Develop policies to ensure Aboriginal people are active participants in health care decisions.
3. Provide a mechanism to fund primary health clinics on reserve.
4. Develop continuing education policy for all health care providers to receive education about the historical context of Aboriginal health and cultural safety.
5. Revise the system to recognize the caregiving role held by many Aboriginal women, and safeguard them against the negative stereotype of Aboriginal women as unfit mothers (Browne, A.J., Fiske J., & Thomas, G.)
6. Coordinate data collection to enable consistency of Aboriginal definitions.
7. Enhance and support the Aboriginal Patient Navigators system.
8. Address discrimination through social justice to prevent systemic discrimination and health inequalities; facilitate social relationships that respect diversity.

5. Conclusions

The purpose of this report was to examine research literature pertaining to Aboriginal health status and data, including barriers and issues for Aboriginal clients accessing health care delivery in Canada. This health status and data has provided an overall negative health disparity for Aboriginal people of Canada in general. The health determinants approach has provided additional factors that have an impact on the health status of a population. It was revealed that the most reliable and available data is for status First Nations people. There are limitations to collecting data for Aboriginal people; in particular, the definition of Aboriginal people used by various government agencies is inconsistent. Three main trends in the Aboriginal population consist of a fast growing, much younger, and increasingly urban-based population.

The health system philosophy of an illness-centered approach opposes the Aboriginal perspective of health as being a balance of emotional, mental, physical and spiritual aspects of self, family, community and nation. The health care delivery system creates numerous barriers for Aboriginal people accessing services. Barriers are created as a result of the power imbalance, opposing philosophies and systemic discrimination. Traditional aboriginal practices are available in urban Aboriginal health centers, and they recognize the historical context of Aboriginal health. As governments and Aboriginal communities move forward together to address aboriginal health issues and close the gaps in health status for Aboriginal people, the system needs to utilize a cultural safety perspective to improve the health outcomes of Aboriginal people.

The system needs to develop an Aboriginal health improvement model with the goal to improve health outcomes for Aboriginal people in Canada. The model consists of policy change

to ensure Aboriginal people are active participants in change. Additional policy is required for education of existing system staff, with a focus on understanding the historical context of Aboriginal health and cultural safety. The model would develop policy to integrate traditional healing practices with mainstream health services. A priority of the process is to ensure Aboriginal clients obtain a regular practitioner. In particular the model would recognize the central role of Aboriginal women in the health of their families. The system also needs to acknowledge the power imbalance. This model would address the determinants of health, such as the absence of discrimination, and include social justice to prevent systemic discrimination, health inequalities, and social relationships that respect diversity.

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